DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION I - MAIN	COMPLETED	
		445502	B. WING				R 17/2018
	PROVIDER OR SUPPLIER			202	REET ADDRESS, CITY, STATE, ZIP CODE RENON SPRINGS ROAD EAST IYRNA, TN 37167		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	08/17/2018 for all p 06/11/2018. All de and no new noncor	it survey was conducted on previous deficiencies cited on ficiencies have been corrected, impliance was found. The ince with all regulations	K	000			
BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
			A. DOILD	///10		F	₹
445502		B. WING				17/2018	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERS OF SMYRNA, L	LC			202 ENON SPRINGS ROAD EAST		
				Ľ	SMYRNA, TN 37167		(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
{E 000}	Initial Comments		{E 0€	00}			
	08/17/2018 for all p 06/11/2018. All def and no new noncon	survey was conducted on revious deficiencies cited on iciencies have been corrected, appliance was found. The name with all regulations					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

INVARIABLE OF PROVIDER OR SUPPLIER THE WATERS OF SMYRNA, LLC SUMMARY STATEMENT OF DESCRIPTION NAMEDER A445502 STREET ADDRESS, CITY, STATE, 21P CODE 202 ENDIN SPRINGS RADA BAST SMYRNA, IN 37167 SMARN SMYRNA, IN 37167 SMYR	DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	15th C	lay / /Othclay	FORM APPROVEI
THE WATERS OF SMYRNA, LLC SAMARAY SYLTEMENT OF DEFICIENCES SHEADBRESS, CITY, STATE, 2IP CODE 202 RNON SPRINGS RODG EAST SMYRNA, TH 37167 SAMARAY SYLTEMENT OF DEFICIENCES SHEADBRESS, CITY, STATE, 2IP CODE 202 RNON SPRINGS RODG EAST SMYRNA, TH 37167 SAMARAY SYLTEMENT OF DEFICIENCES SHEADBRESS, CITY, STATE, 2IP CODE 202 RNON SPRINGS RODG EAST SMYRNA, TH 37167 SAMARAY SYLTEMENT OF DEFICIENCES SHEADBRESS, CITY, STATE, 2IP CODE 202 RNON SPRINGS RODG EAST SMYRNA, TH 37167 SAMARAY SYLTEMENT OF DEFICIENCES SHEAD RECURSORY OR LEG DENTIFY THE SHEAD LOCKING K 222 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a bool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system see arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5, 11A 1.2.4 DELAXED EGRESS CLOCKING ARRANGEMENTS Approved, listed delayed-gress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION (
THE WATERS OF SMYRNA, LLC SIMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION.) Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5, 1, 19.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5, 17.1.2.4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	P	C#1	445502	100 mg 10		06/11/2018
THE WATERS OF SMYNNA, LLC SMYNNA, THE 37467 SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FRESH GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FRESH GEACH DEFICIENCY SS=D K 222 Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress sick unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.5, 19.2.2.2.5, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system for is constantly monitored at an attended location within the locked space; protected by a complete smoke detection system for is constantly monitored at an attended location within the locked space is protected by a complete smoke detection system for is constantly monitored at an attended location within the locked space is protected by a complete smoke detection system for is constantly monitored at an attended location within the locked space is protected by a complete smoke detection system for is constantly monitored at an attended location within the locked space is protected by a comp	NAME OF F	PROVIDER OR SUPPLIER				
Egress Doors CFR(s): NFPA 101 Egress Doors CFR(s): Maintenance Director will reconfigure door latch height to be at or below 48 inches to courtyard gate exits by 6/22/18. 2. How will you identify other door latches that may be affected by the same deficient practice? The facility's Administrator audit all facility door latches on 6/11/18 to ensure no other doors were affected by this deficient practice. This audit yelided no further conerns. 3. What measures will be put into place or what systematic that the deficient practice does not recur? Con 6/11/18, the f	THE WAT	ERS OF SMYRNA, L	LC	2400	MYRNA, TN 37167	
Egress Doors Doors in a required means of egress shall not be equipped with a tatch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times, or other such reliable means available to the staff at all times. 18. 2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2.1, 12.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	PREFIX	(FACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION
Mukson 6185/15	SS=D	Egress Doors Doors in a required equipped with a late use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and prov rapid removal of ocl locks; keying of all all times; or other s to the staff at all tim 18.2.2.2.5.1, 18.2.2 SPECIAL NEEDS I Where special lock safety needs of the Clinical or Security being met. In additi- electrical locks that upon loss of power protected by a sup- system and the loc complete smoke de constantly monitore within the locked s and detection syste doors upon activati 18.2.2.2.5.2, 19.2.2 DELAYED-EGRES ARRANGEMENTS Approved, listed de installed in accorda permitted on door and y DIRECTOR'S OR PROVID	ch or a lock that requires the from the egress side unless lowing special locking OR SECURITY THREAT ing arrangements for the eds of the patient are used, evice shall be permitted on visions shall be made for the ecupants by: remote control of locks or keys carried by staff at uch reliable means available nes. 2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 OCKING ARRANGEMENTS ing arrangements for the patient are used, all of the Locking requirements are on, the locks must be fail safely so as to release to the device; the building is ervised automatic sprinkler ked space is protected by a setection system (or is ed at an attended location pace); and both the sprinkler ems are arranged to unlock the inc. 2.2.5.2, TIA 12-4 S LOCKING elayed-egress locking systems ance with 7.2.1.6.1 shall be assemblies serving low and		 What corrective action(s) will be accomplished for the deficient practice. The facility's Maintenance Director will reconfigure door latch height to be at a below 48 inches to courtyard gate exit. 6/22/18. How will you identify other door latcher may be affected by the same deficient practice? The facility's Administrator audit all factor doors were affected by this deficient practice. This audit yielded no further concerns. What measures will be put into place what systematic changes will you make ensure that the deficient practice does recur? On 6/11/18, the facility's Administrator provided face to face re-education to facility's Maintenance Director regard Americans with Disabilities Act require with an emphasis on door latch height. How will the corrective action(s) be monitored to ensure the deficient prawill not recur? Beginning on 6/18/18, the facility's Maintenance Director will conduct ar of all egress doors weekly x 4 weeks. concerns noted, then decrease audit every month x 2 months. The facility' Maintenance Director will present the 	e? I or s by es that cility other or the to s not or the ling ements t. actice a audit If no to s e

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 6-25-18

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO.	0038-0391
TATEME	nt of deficiencies n of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDII	TIPLE CONSTRUCTION ING 04 - MAIN		PLETED -
COMPANIES CONTRA		445502	B. WING	STREET ADDRESS, CITY, STATE, ZIP COL		1/2018
THE REAL PROPERTY.	F PROVIDER OR SUPPLIER FATERS OF SMYRNA, L	LC		202 ENON SPRINGS ROAD EAST SMYRNA, EN: 37167		
(X4) IE PREFIX TAG	(EACH DEFICIENC	REMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIME ACTION SI CROSS REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 22	ordinary hazard conthroughout by an an fire detection system automatic sprinkler 18.2.2.2.4, 19.2.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled installed in accordance installed in accordance with 7. door assemblies in by an approved, sundetection system an automatic sprinkler 18.2.2.2.4, 19.2.2.2 This REQUIREMENTS Based on observation and the egress The findings included Observation on 06/door latch height his the courtyard gate NFPA 101, 19.2.2.2 7.2.1.7.1 (2012 Edito 17.2.1.7.1 (2012 Edito 17.2.1.8.2.2.1.7.1).	ntents in buildings protected pproved, supervised automatic m or an approved, supervised system. 2.4 DLLED EGRESS LOCKING Egress Door assemblies ance with 7.2.1.6.2 shall be 2.4 Y EXIT ACCESS LOCKING access door locking in 2.1.6.3 shall be permitted on buildings protected throughout apervised automatic fire and an approved, supervised system. 2.4 NT is not met as evidenced tions, the facility failed to s doors. e: 2.11/2018 at 2:30 PM, revealed igher than 48 inches on all of exits. 2.1 (2012 Edition), NFPA 101, ition) director was present for the later acknowledged by the great the exit conference on	K 22	K 223 1. What corrective action(s) will accomplished for the deficient On 6/11/18, the facility's Main Director adjusted the tension shoot latch for the cross corridor.	pe practice? Itenance screws to the problem to by room 405	7/28/18
	23 Doors with Self-Clo			which remedied the dencient	practice.	et Page 2 of 5
ORM CM	2-2567(02-99) Previous Versions	S Upsoiete Event ID: 17 NQ2	· L	· m		3.2.2.2.2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CONTRACTOR OF THE PARTY OF THE	C EOD MEDICINE	E & MEDICAID: SERVICES		0	MB NO. 0938-0391
TATEMENT	S FOR MEDICARI OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED 06/11/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
				02 ENON SPRINGS ROAD EAST	
THE WAT	ERS OF SMYRNA,	N. C.	S	MYRNA, TN 37167	
(X4) ID PREFIX TAG	CACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
K 223	or horizontal exit, area enclosure an closed position, undevice complying closes all such do compartment or extended the such do compartment or extended the such do compartment or extended the such document and the such	losing Devices assageway, stairway enclosure, smoke barrier, or hazardous e self-closing and kept in the nless held open by a release with 7.2.1.8.2 that automatically lors throughout the smoke entire facility upon activation of: af fire alarm system; and tectors designed to detect brough the opening or a required system; and ker system, if installed; and 1.2.8, 19.2.2.2.7, 19.2.2.2.8 ENT is not met as evidenced the facility failed to maintain the deciman test on 06/11/2018 at 2:43 cross corridor by room 405 did	K 223	on 6/11/18, the facility's Maintenan Director conducted an audit of all condors to ensure timely self-release a proper latch. No other concerns were 3. What measures will be put into place what systematic changes will you mensure that the deficient practice direcur? On 6/11/18, the facility's Administre provided face to face re-education the requirements of self-closing smeasure doors during the activation alarm. 4. How will the corrective action(s) be monitored to ensure the deficient will not recur? Beginning on 6/18/18, the facility's Maintenance Director will conduct on all smoke barrier doors weekly to ensure timely self-closure and latthe activation of a fire alarm. If no	ce pridor and re noted. se or make to ooes not ator regarding ooke of a fire practice an audit x 4 weeks stch during on-going
	not self close and NFPA 101, 8.3.3. (2010 Edition), N	I latch within the frame. 1 (2012 Edition), NFPA 80, 7.1.4 FPA 80 6.1.4.2 (2010 Edition)		concerns noted, then decrease and monthly x 2 months. The facility's Maintenance Director will present facility's QAPI Committee with a suaudits during monthly QAPI Comm	the ummary of
K 923 SS=D	findings which we administrator dur 06/11/2018. Gas Equipment	e director was present for the ere later acknowledged by the ring the exit conference on Cylinder and Container Storag	K 92	meeting for further review and/or recommendations.	7/28/18
	Gas Equipment	- Cylinder and Container Storage	_	On 6/11/18, the facility's Maintena	nce
	567(02-99) Previous Versi	ions Obsolete Event ID: T7K0	221	Facility ID: TN7509 If cont	inuation sheet Page 3 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

OMB NO. 0938-0391

DEPART	WENT OF HEALT	HAND HUMAN SERVICES		SMB NO.	0008-0391
CENTERS FOR MEDICARE & MEDICALD SERVICES		A BUILDING 01	CONSTRUCTION COM	ESURVEY PLETED -	
		445502	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	FIFEVE
NAME DE P	ROVIDER OR SUPPLIE	R	STE	REET ADDRESS, CITY, STATE, 21, CODE ENON SPRINGS ROAD EAST	
110002002			202	TYRNA, IN 37167	
THE WAT	ERS OF SMYRNA,		300	CORRECTION	(XS)
(X4) ID PREFIX TAG	The state of the s	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	PREFIX TAG	EASH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY:	COMPLETION
		- 10 C C C C C C C C C C C C C C C C C C		Director secured the 3 noted unsecure	1
			K 923	oxygen storage bottles.	I
K 923	Continued From	page 3	R 323		Į.
		squal to 3 000 cubic feet	ľ I	2. How will you identify other unsecured	1
	ac lagation	c are designed. Constitution and		oxygen storage bottles that may be affected	1
	ventilated in acco	ordance with 5.1.3.3.2 and		by the same deficient practice?	1
	5 1 3 3 3.			On 6/11/18, the facility's Administrator	
	>300 but <3,000	s are outdoors in an enclosure or		conducted an audit on all oxygen storage	1
	Storage location	ed interior space of non- or	l ^a	rooms to ensure proper securing of stored	1
	the second and an administration	inio construction. Will does to	1	oxygen bottles. No other concerns were	
		that can be secured. Uniting		noted.	
	A COUNTY OF THE REAL PROPERTY OF THE PROPERTY	CHARLES VANDOUS TREATMENTS OF BUILDING COLUMN			
		cambishines of 20 icci (o recon	1	3. What measures will be put into place or	1
	" simble for adl or a	inclosed in a capitlet of		what systematic changes will you make to ensure that the deficient practice does not	
	noncombustible	CONSTRUCTION HAVING A HIMMEN	i i	recur?	1
	110 hr fire prote	ction rating.		recur	
	I am than or on	tal to 300 cubic feet	1	Beginning on 6/18/18 and to be completed	i
	the the second	co companient individual		by 7/1/18, the facility's Maintenance	
	The second secon	La for management the line in pancin		Director, Administrator, and/or	
	The same and south	an addrenate volume of loss than	" [Administrative Staff designee will provide	
	in a nation to 3(10)	chine reel are not required to		100% staff education with post-test	
	stored in an end	closure. Cylinders must be ecautions as specified in 11.6.2.		regarding proper storage of oxygen bottles.	
	A condianal	eign readable holl 3 leet is on		4. How will the corrective action(s) be	1
	anah daar or de	the of a cylinder storage room,	1	4. How will the corrective action(s) be monitored to ensure the deficient practice	
	the see the cign	includes the wording as a		will not recur?	
	minimum "CAL	HOW OXIDIZING QUOLEDI	t		
	THE PARTY OF THE PARTY IN	HALKICA SIMILIPOLITUS	-4	Beginning on 6/18/18, the facility's	
	increase in minn	ned so cylinders die used in olde.		Maintenance Director, Administrator, and/o	
	of which thou a	to received from the supplier.	ĺ	Administrative Staff designee will conduct a	n
	I we walken down	c are searenaied iluit iuii	024	audit of all oxygen storage rooms daily x 4	
	cylinders. Whe	en facility employs cylinders with		weeks to ensure proper oxygen bottle	
	The second section is a second section of the second	re gauge, a threshold pressure pty is established. Empty cylinder stored	rs	storage. If no on-going concerns noted, ther	'
	considered em	avoid confusion. Cylinders stored		decrease audit to 3 x per week x 2 months. The facility's Maintenance Director will	
	I' All and are	protected HOM Wediller.		present the facility's QAPI Committee with a	,
1	11101 1110	44 3 3 11 3 4 11.0.3 [PH 11.00]		summary of audits during the facility's	-
	This REQUIRE	MENT is not met as evidenced	1	monthly QAPI Committee meeting for	-
1	II have at			further review and/or recommendations.	
	Based on an o	observation, the facility failed to			
1	properly store	the oxygen bottles.		if continuation	sheet Page

CENTER	MENT OF HEALTH IS FOR MEDICARE OF DEFICIENCIES	AND HUMAN SERVICES ** MEDICALD SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	FORM OMB NO (X3) DAT	APPROVED 0938-0391 E SURVEY	
ND PLAN OF CORRECTION DENTIFICATION NUMBER:		A, BUILDING	G 01 - MAIN				
		445502	B. WING	THE RESERVE OF THE PERSON NAMED IN	111/2018		
NAME OF PROVIDER OR SUPPLIER THE WATERS OF SMYRNA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167				
(X4) ID PREFIX TAG	VENCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 923	3 oxygen storage I hall oxygen storag NFPA 99 11.3.2.1	/11/2018 at 10:17 AM, revealed pottles not secured in the 200 e room.	K 92	3			
	administrator durin 06/11/2018.	ng the exit conference on					